APPENDIX D

PREAUTHORIZATION FOR INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES (IFDDS) SUPPORT WAIVER

General Information Chapter for Prior Authorization

All Manuals

Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and appeal processes and questions and answers to frequently asked questions.

The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

Preauthorization for Waiver Services

General Information

Prior to requesting authorization of services under the waivers, the individual must be deemed Medicaid eligible by the Department of Social Services and meet waiver criteria. Criteria for enrollment differs from waiver to waiver. The following chart indicates the PA entity that will accept requests for enrollment, and the alternate institutional placement. It is important to note that an individual can only be enrolled in one waiver at a time; if transferring from one waiver to another, there cannot be overlaps in dates. Please see Chapter IV for enrollment processes.

Waiver	Send Enrollment To	Alternate Institutional Placement
Elderly or Disabled with Consumer Direction (EDCD) Waiver	KePRO	Skilled Nursing Facility
AIDS/HIV Waiver	KePRO	Skilled Nursing Facility or Acute Hospital
Individual and Family Developmental Disabilities Support (IFDDS)Waiver	DMAS	Intermediate Care Facility for Mentally Retarded
Technology Assisted (Tech) Waiver	DMAS	Skilled Nursing Facility or Acute Hospital
Mental Retardation (MR) Waiver	DMHMRSAS	Intermediate Care Facility for Mentally Retarded
Day Support (DS) Waiver for Individuals with Mental Retardation	DMHMRSAS	Intermediate Care Facility for Mentally Retarded
Alzheimer's Assisted	DMAS	Skilled Nursing Facility

Living (AAL)Waiver		

Once enrolled in the waiver, services may be requested through the PA entity. The following chart summarizes Virginia's Home and Community Based Waivers, the services available under each waiver, and the PA entity that will review requests for services.

Waiver Services	AIDS Waiver	DD Waiver	EDCD Waiver	MR Waiver *	Tech Assisted	Day Support Waiver*	Alzheimer's Waiver	PA Entity*	Requires PA	Retroactive Authorization
Adult Companion Care – Agency		X		X				Contractor	Yes	Yes
Adult Companion Care – Consumer Directed		X		X				Contractor	Yes	Yes
Adult Day Health Care			X					Contractor	Yes	See Ch IV
Assisted Living							X	DMAS	No	No
Assistive Technology		X		X	X			Contractor	Yes	No
Congregate Residential				X				*	Yes	No
Environmental Mods		X		X	X			Contractor	Yes	No
Case Management	X							Contractor	Yes	See Ch IV
Crisis Stabilization		X		X				Contractor	Yes	See Ch IV
Day Support Regular		X		X		X		Contractor	Yes	No
Day Support High Intensity		X		X		X		Contractor	Yes	No
Family/Caregiver Training		X						Contractor	Yes	No
In-Home Residential		X		X				Contractor	Yes	No
Enteral Nutrition	X							Contractor	Yes	No
Personal Care – Agency	X	X	X	X	X			Contractor; Tech Waiver by DMAS	Yes	Yes
Personal Care – Consumer Directed	X	X	X	X				Contractor	Yes	Yes
PERS		X	X	X				Contractor	Yes	No
Private Duty Nursing-RN	X				X			AIDS Waiver by Contractor; Tech Waiver by DMAS	Yes	AIDS Waiver – No; Tech Waiver - Yes
Private Duty Nursing-LPN	X				X			AIDS Waiver by Contractor; Tech Waiver by DMAS	Yes	AIDS Waiver – No; Tech Waiver - Yes
Respite Care - Agency	X	X	X	X	X			Contractor; Tech Waiver by DMAS	Yes	Yes
Respite Care - Consumer Directed	X	X	X	X				Contractor	Yes	Yes
Skilled Nursing –RN		X		X				Contractor	Yes	No

Skilled Nursing - LPN		X		X				Contractor	Yes	No
Supported Employment-Individual		X		X				Contractor	Yes	No
Supported Employment – Enclave		X		X				Contractor	Yes	No
Therapeutic Consultation		X		X				Contractor	Yes	No
Prevocational Services (all)		X		X		X		Contractor	Yes	No
PERS RN		X		X				Contractor	Yes	No
PERS LPN		X		X				Contractor	Yes	No
Crisis Supervision		X		X				Contractor	Yes	See Ch IV
PERS Installation		X		X				Contractor	Yes	No
Service Facilitation Visits (all)	X	X	X	X				N/A	No	Yes

All Waiver Services requested under the Mental Retardation Waiver and the Day Support Waiver are processed through DMHMRSAS.

****Enrollments to the DD, Tech, and Alzheimer's Waivers are performed by DMAS.***

*****Once the individual is successfully enrolled by DMAS in the DD and Tech Waivers, the service requests are processed through the contractor.***

Contractor = KePRO

Preauthorization for IFDDS Waiver Services

After the Case Manager obtains confirmation of enrollment by DMAS, they must assure that the contractor receives the current approved Plan of Care (DMAS 456) prior to submitting requests for service. All services identified on the DMAS 456 must be approved by DMAS as evidenced by the Health Care Coordinators signature and date. Services are not authorized retroactively, unless specifically indicated within Chapter IV.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. The following chart shows the entity that receives letters generated from MMIS:

	Provider	Case Manager	Enrolled Individual	Comments
Approval	X	X	X	
Pend	X	X		
Reject	X	X		
Denial/Partial Denial	X	X	X	Appeal Rights are included in all denials/partial denials

DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between

various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR).

All service requests must be submitted through the Case Manager. If services are not requested within 10 days of start of care, approvals will begin on the day the request was received by the contractor.

Plans of Care and Service Authorizations

Service requests revolve around the POC date. Upon initial enrollment to the DD Waiver, services must begin within 60 days or an extension letter, approved by a DMAS Health Care Coordinator, must be obtained and sent to the contractor. (See Chapter IV for more details on extension letters.) All POCs must be reviewed, signed and dated by the enrolled individual indicating agreement to the POC.

Plans of care must be renewed annually. If the POC is not renewed prior to the last date in the previously approved year, the service(s) will be ended and will not be reinstated until a renewal plan is received by the contractor.
Plan revisions are necessary when there has been a change in the amount of an existing service, or a service has added or terminated from the individuals plan. If adding a service, the POC revision must be approved by DMAS, sent to the contractor, then the request for the additional service made.

Submitting Requests for Services

After the individual is successfully enrolled by DMAS and the contractor has the current POC with all identified services, the case manager may begin submitting requests. The contractor will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. The contractor has one business day to process requests from the date the request is received. Specific information regarding the methods of submission may be found at the contractor's website, http://DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at (804) 497-1333. The program will take you through the steps needed to receive approval for service requests.

The following chart shows the information necessary to process the request for specific services. Although these forms may not be required by the contractor, pertinent information from these forms will be required to process the request. Upon QMR of the provider or case management agency, the forms must be present in the record and fully completed. These documents will be compared against the information submitted to the contractor. In addition, the contractor may require a daily schedule of the individual.

HCPCS code	Description	PA Required	PA Units Requested	PA Units Approved	Service limits	Units	Forms currently submitted for authorization
H2011	Crisis Stabilization- Intervention	Y	Week	Hr/2Wks	60 Day	N/A	Assessment-Documentation done within 72 hours or 457
H0040	Crisis Stabilization - Supervision	Y	Week	Hr/2Wks	60 day	N/A	DMAS 457
H2014	In-home Residential Support	Y	Week	Month	None	Monthly	DMAS 457 & schedule
H2023	Supported Employment - Individual	Y	Week	Month	40 Hrs/Wk--- 780 units / Year	Hour	DMAS 457 & schedule
H2024	Supported Employment - Enclave	Y	Week	Month			
H2025	Pre-Vocational Services, Regular Intensity	Y	Week	Month			DMAS 457 & schedule
H2025 U1	Pre-Vocational Services, High Intensity	Y	Week	Month			DMAS 457 & schedule
97537	Day Support, Regular, Center Based	Y	Week	Month	**	Month	DMAS 457 & schedule
97537 U1	Day Support - High Intensity Center Based	Y	Week*	Month			
97537	Day Support - Regular, Non-Center Based	Y	Week*	Month			
97537 U1	Day Support, High Intensity, Non-Center Based	Y	Week*	Month			
97139	Therapeutic Consultation	Y	Week	Month	None	Hour	DMAS 457, TC plan for increases
99199 U4	Environmental Modifications - Maintenance	Y	1	1	Together cannot exceed $5,000 per Plan year	Units = 1	Description of item requested and actual cost to provider (this is provided to the Case Manager from the provider); evaluation from appropriate professional & provider invoice at PA with actual cost. 30% to invoice actual cost. Always want wholesale cost.
S5165	Environmental Modifications- Rehab	Y	1	1			
S5165	Environmental Modifications - Structural Modification	Y	1	1			
S5165	Environmental Modification - Supply Cost Only	Y	1	1			
S5165	Environmental Modification – Transportation Modification	Y	1	1			
T1999	Assistive Technology Rehabilitation	Y	1	1	Together cannot exceed $5,000.00 per year		
T1999	Assistive Technology Off shelf item	Y	1	1			
T1999 U5	Assistive Technology Maintenance Cost	Y	1	1			
T1002	Skilled Nursing Services, RN	Y	Week	Week	No Limits		CMS 485 Nursing plan of care (Q6Mths)
T1003	Skilled Nursing Services, LPN	Y	Week	Week	No Limits		CMS 485 Nursing plan of care
T1019	Personal Care	Y	Week	Month	**	Hour	DMAS-97A/B, DMAS 99
H2000	Personal care attendant Care - Initial Comprehensive Visit	N	N/A	N/A	1/6 Months		N/A
S5109	Personal care attendant Care - Consumer Training	N	N/A	N/A	1/6 Months		N/A
99509	Routine Visit	N	N/A	N/A	1/30 Days		N/A
99199 U1	Criminal Record Check	N	N/A	N/A	6/6 Months		N/A

T1028	Reassessment Visit	N	N/A	N/A	2/6 Months		N/A
S5116	Management Training	N	N/A	N/A	4/6 Months		N/A
99080	Fiscal Admin Cost	N	N/A	N/A	No Limits		N/A
99199	CPS Registry Check	N	N/A	N/A	No Limits		N/A
T1005	Respite Care Services, Aide, Hour	Y	Week	720	720 Hrs/Calendar Yr		DMAS- 97A/B, DMAS 99, for DMHMR providers 457 and schedule
S5150	CD- Respite	Y	Week	720	720 Hrs/Calendar Yr		DMAS 97AB, 99AB
H2000	CD- Respite Comp Visit	N	N/A	N/A	1/6 Months		N/A
S5109	CD- Respite Consumer Training	N	N/A	N/A	1/6 Months		N/A
99509	CD- Respite Routine Visit	N	N/A	N/A	1/30 Days		N/A
T1028	CD- Respite Reassessment Visit	N	N/A	N/A	2/6 Months		N/A
99080	CD- Respite Fiscal Agent	N	N/A	N/A	No Limits		N/A
S5136	CD-Companion Care	Y					
S5135	Companion Care	Y	Week	Month	744 Hrs/Mo		DMAS-457, 97A/B if you can ask for a schedule.
S5160	PERS Installation	Y	Visit	1/6 Mo	1/6 Months		DMAS 457
S5160 U1	PERS and Medication Installation	Y	Visit	1/6 Mo	1/6 Months		DMAS 457
S5161	PERS Monitoring	Y	Visit/Mo	1/Mo	1/30 Days		DMAS 457
S5185	PERS and Medication Monitoring	Y	Visit/Mo	1/Mo	1/30 Days		DMAS 457
H2021 TD	PERS Nursing - RN	Y	Visit/2 Wks	1/2Wks	1/14 Days		DMAS 457
H2021 TE	PERS Nursing - LPN	Y	Visit/2 Wks	1/2 Wks	1/14 Days		DMAS 457
S5111	Family Caregiver Training	Y	Year	Year	80 Hrs/365 Days		DMAS 457- provider

Early Periodic Screening Diagnosis and Treatment

Prior Authorization Section

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the recipient.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS-contracted managed care organization as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered and is medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

All Medicaid and FAMIS Plus services that are currently preauthorized by the PA contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, http://DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at (804) 497-1333.

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all pre authorization reviews of prior authorized Medicaid services. Service requests that are part of a community based waiver are the sole exception to this policy. Waivers are exempt from EPSDT criteria because the federal approval for waivers is strictly defined by the state. The waiver program is defined outside the parameters of EPSDT according to regulations for each specific waiver. However, waiver recipients may access EPSDT

treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

Examples of EPSDT review process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current treatment modalities.

The review process as described is to be applied across all non waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: hearing aids, substance abuse treatment, non waiver personal care, assistive technology, and nursing. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).